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11-30-2004

Proposed Rules
of
The Tennessee Department of Labor and Workforce Development
Division of Workers' Compensation

Chapter 0800-2-

Medical Fee Schedule

Presented herein are proposed rules of the Tennessee Department of Labor and Workforce Development submitted pursuant to T.C.A. Section 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Department of Labor and Workforce Development to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed rules are published. Such petition, to be effective, must be filed with the Workers' Compensation Division, Second Floor of the Andrew Johnson Tower located at 710 James Robertson Parkway, Nashville, TN 37243-0661 and in the Department of State, Eighth Floor, Tennessee Tower, William Snodgrass Building, 312 8th Avenue North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rule, or submitted by a municipality which will be affected by the rules, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: E. Blaine Sprouse, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-0064.

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The Medical Fee Schedule of the Tennessee Division of Workers' Compensation shall be based upon the Health Care Financing Administration's (HCFA) Medicare Resource Based Relative Value Scale (RBRVS), utilizing HCFA's national relative value units and Tennessee specific conversion factors adopted by the Tennessee Division of Workers' Compensation. Parties using this schedule should also be familiar with the Division's Medical Cost Containment Program rules, 0800-2-11-.01, et seq., the In-patient Hospital Fee Schedule rules, 0800-2- __ .01, et seq., the most current CPT, the Health Care Financing Administration Common Procedure Coding System (HCPCS), and the ASA Relative Value Guide**.**

This Medical Fee Schedule must be used in conjunction with Medical Cost Containment Program Rules and the In-patient Hospital Fee Schedule Rules. The definitions in those rules will be used in conjunction with these rules

0800-2- -.01 Effective Date and Coding References

This fee schedule shall be effective July 1, 2005 and the most current versions of CPT and the Medicare RBRVS shall automatically be applicable upon their effective dates.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2- -.02. General Information and Instructions for Use

(1) Format

This schedule consists of the following sections**:** Medicine (including Evaluation and Management Services), General Surgery, Neuro- and Orthopedic Surgery, Radiology, Pathology, Anesthesiology, Injections, Durable Medical Equipment, Orthotics, Pharmacy, Physical and Occupational Therapy, Ambulatory Surgical Treatment ("AST"), Chiropractic, and Ambulance Services. Providers are to use the section(s) which contain the procedure(s) they perform, or the service(s) they render.

(2) Reimbursement

Reimbursement to providers shall be the lesser of the following:

(a) The provider's usual charge

(b) The fee calculated according to the Tennessee Division of Workers' Compensation ("TDWC") Fee Schedule

(c) The MCO/PPO contracted price

(d) In no event shall reimbursement be in excess of the TDWC Fee Schedule, unless otherwise provided in the Division's rules. Charges in excess of the TDWC Medical Fee Schedule shall result in civil penalties, at the Commissioner's discretion, of $10,000.00 each assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee. At the Commissioner's discretion, such provider shall also be reported to the appropriate certifying board or other appropriate authority, and may be subject to exclusion from participating further in providing care under the Tennessee Workers' Compensation Act.

(3) Fee Schedule Calculation

The TWCD Medical Fee Schedule can be calculated for any specific CPT code by multiplying the national "transitioned nonfacility total relative value units" (RVUs) by the conversion factor applicable to that CPT.

(4) Conversion Factors

The conversion factors applicable to this Fee Schedule are as follows:

	Conversion Factor	Percent of Medicare
Anesthesia	$52.42	140%
General Surgery	$74.88	200%
Neuro-surgery (Board Certified)	$121.68	325%
Orthopedic Surgery (Board Certified)	$121.68	325%
Physical and Occupational Therapy	$48.67	130%
Radiology	$65.52	175%
Medicine (includes Evaluation and Management)		
For Office Visits	$59.90	160%
For Emergency Care	$131.04	350%
Pathology	$56.16	150%
Chiropractic Care	$48.67	130%
Home Health Care	$37.44	100% of LUPA*
Home Infusion	$46.80	125% of LUPA*
Dentistry	$37.44	100%
Long-term In-patient Healthcare	$37.44	100%
Clinical Psychology	$34.77	100%

*"LUPA" refers to the Medicare rates for Low Utilization Payment Adjustment

Pathology codes that do not have RVUs listed in the Medicare RBRVS should be reimbursed 200% of Tennessee Medicare for Clinical Diagnostic Laboratory Fee Schedule allowance, with 30% of reimbursable amount for the Professional Component and 70% of the reimbursable amount for the Technical Component.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

(5) Forms

The following forms (or their replacements) should be used for provider billing:
HCFA 1500
UB 92

Bills for reimbursement should be sent directly to the party responsible for reimbursement. In most instances, this is the Insurance Carrier or the Self-Insured Employer. Insurance Carriers and/or Employers shall furnish this information to the Providers.

(6) Penalties for Violations of Fee Schedules and Medical Cost Containment Rules

The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner, shall have the authority to issue civil penalties up to and including $10,000.00 per violation for violations of the Medical Fee Schedule, In-patient Hospital Fee Schedule or the Medical Cost Containment Program Rules after notice and an opportunity for a contested case hearing pursuant to the Uniform Administrative Procedures Act, T.C.A. 4-5-101, et seq.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2- .03 General Guidelines

Guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in a particular section and provide explanations regarding terms that apply only to a particular section.

The Guidelines found in the most current CPT apply to the following**:** Medicine (includes Evaluation and Management), General Surgery, Neuro-surgery, Orthopedic Surgery, Chiropractic, Physical and Occupational Therapy, Home Health Care, Home Infusion, Ambulatory Surgical Treatment ("AST"), Radiology, and Pathology. CDT-3 Codes of current dental terminology prescribed by the American Dental Association, including the terminology updates and revision issued in the future by the American Dental Association shall be used for all Dentistry services.

In addition to the Guidelines found in the CPT, the following Tennessee Division of Workers' Compensation ("TDWC") Guidelines also apply. Whenever a conflict exists between the Medical Fee Schedule Rules and any other fee schedule, rule or regulation these Medical Fee Schedule Rules shall govern.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2- -.04 Surgery Guidelines

(1) Multiple Procedures: Reimbursement shall be based on 100% of the physician's usual charge for the major procedure (not to exceed 100% of the Medical Fee Schedule allowable) plus 50% of the physician's usual charge for the lesser or secondary procedure (s) (not to exceed 50% of the Medical Fee Schedule allowable).

(2) Services Rendered by More Than One Physician:

(a) Concurrent Care: One attending physician shall be in charge of the care of the injured employee. However, if the nature of the injury requires the concurrent services of two or more specialists for treatment, then each physician shall be entitled to the listed fee for services rendered.

(b) Surgical Assistant: Only a physician who assists at surgery may be reimbursed as a surgical assistant. To identify surgical assistant services, Modifier 80 or 81 should be added to the surgical procedure code which is billed. A surgical assistant must submit a copy of the operative report to substantiate the services rendered. Reimbursement is limited to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Fee Schedule amount.

(c) Two Surgeons: For reporting see the most current CPT. Each surgeon must submit an operative report documenting the specific surgical procedure(s) provided. Each surgeon must submit an individual bill for the services rendered. Reimbursement must not be made to either surgeon until the carrier has received each surgeon's individual operative report and bill. Reimbursement to each surgeon must be made at the provider's usual charge or the maximum allowable Fee Schedule amount, whichever is less.

(3) When a surgical fee is chargeable, no office or hospital visit charge shall be allowed for the day on which this surgical fee is earned, except if surgery is performed on the same day as the physician's first examination. All exceptions require use of the appropriate modifiers and shall be filed BR.

(4) Certain of the listed procedures in the Medical Fee Schedule are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge.

(5) Lacerations ordinarily require no aftercare except removal of sutures. The removal is considered a routine part of an office or hospital visit and shall not be billed separately unless such sutures are removed by a provider different from the provider administering the sutures.

0800-2-0-.05 Anesthesia Guidelines

(1) General Information and Instructions.

The current ASA Relative Value Guide, by the American Society of Anesthesiologists will be used to determine reimbursement for codes that do not appear in the RBRVS. These values are to be used only when the anesthesia is personally administered by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) who remains in constant attendance during the procedure, for the sole purpose of rendering such anesthesia service.

To order the Relative Value Guide, write to the American Society of Anesthesiologists; 520 N Northwest Highway; Park Ridge, IL 60068-2573 or call (847)825-5586.

When anesthesia is administered by a CRNA not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the provider's usual charge or the Anesthesia Reimbursement Allowance (ARA), which ever is less. No payment will be made to the surgeon supervising the CRNA.

When anesthesia is administered personally by an anesthesiologist or administered by a care team involving an anesthesiologist and CRNA, reimbursement shall not exceed 100% of the provider's usual charge or the ARA, whichever is less.

(2) Anesthesia Values

Each anesthesia service contains two value components which make up the charge and determine reimbursement: a Basic Value and a Time Value.

(a) Basic Value relates to the complexity of the service and includes the value of all usual anesthesia services except the time actually spent in anesthesia care and any modifiers. The Basic Value includes usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood products incidental to the anesthesia or surgery and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). When multiple surgical procedures are performed during an operative session, the Basic Value for anesthesia is the Basic Value for the procedure with the highest unit value. The Basic Values in units for each anesthesia procedure code are listed in the current ASA Relative Value Guide.

(b) Time Value

Anesthesia time starts when the anesthesiologist or CRNA begins to prepare the patient for induction of anesthesia and ends when the personal attendance of the anesthesiologist or CRNA is no longer required and the patient can be safely placed under customary, postoperative supervision. Anesthesia time must be reported on the claim form as the total number of minutes of anesthesia. For example, one hour and eleven minutes equals 71 minutes of anesthesia. The Time Value is converted into units for reimbursement as follows:

Each 15 minutes or any fraction thereof equals one (1) time unit.

Example: 71 minutes of anesthesia time would have the following time units: 71/15 = 5 Time Units.

No additional time units are allowed for recovery room observation monitoring after the patient can be safely placed under customary postoperative supervision.

(3) Total Anesthesia Value

The total anesthesia value (TAV) for an anesthesia service is the sum of the Basic Value (units) plus the Time Value which has been converted into units. The TAV is calculated for the purpose of determining reimbursement.

(4) Billing

Anesthesia services must be reported by entering the appropriate anesthesia procedure code and descriptor into Element 24 D of the HCFA 1500 Form. The provider's usual total charge for the anesthesia service must be entered in Element 24 F on the HCFA 1500 Form. The total time in minutes must be entered in Element 24 G of the HCFA 1500 Form.

(5) Reimbursement

Reimbursement for anesthesia services must be made at the provider's usual charge or the Anesthesia Reimbursement Allowance (ARA)**,** whichever is less. The ARA is calculated by determining the total anesthesia value for the service rendered and then multiplying that value by an established conversion factor which has a dollar value.

Total Anesthesia Value (Basic Value + Time Value + Physical Status Modifiers when applicable)

X Conversion Factor = ARA

The conversion factor for Tennessee Workers' Compensation is $52.42.

(6) Methodology for Calculating ARAs

(a) Refer to the Anesthesia Codes in the Relative Value Guide to locate the applicable anesthesia procedure code and corresponding Basic Value.

(b) Determine Time Units.

(c) Any minutes which exceed the whole units are counted as whole units.

(d) Add Basic Value and Time Units to determine Total Anesthesia Value (TAV).

(e) Multiply TAV by the Conversion Factor, $52.42, to obtain the ARA.

(7) Special Anesthesia Services

(a) Unusual Circumstances (Modifiers 22 and 23).

Under certain circumstances, the anesthesia service(s) provided may vary significantly from those usually required for the listed procedures. The use of modifiers is appropriate for these instances.

(b) Unusual Services: When the service(s) provided is greater than usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number or by use of the separate five-digit modifier code 09922. A report is required.

(c) Unusual Anesthesia: Occasionally a procedure which usually requires either no anesthesia or local anesthesia, because of unusual circumstances, must be done under general anesthesia. This circumstance may be reported by adding the modifier 23 to the procedure code of the basic service or by use of the separate five digit modifier code 09923.

(d) For additional modifiers for physical status and qualifying circumstances see the Relative Value Guide. The use of modifiers does not guarantee additional reimbursement.

(8) Monitored Anesthesia Care

When an anesthesiologist or CRNA is required to participate in, and be responsible for, monitoring the general care of the patient during surgery but does not administer anesthetic, such professional services must be billed and reimbursed as though an anesthetic were administered; that is, basic anesthesia plus time.

(9) Medical Direction Provided by Anesthesiologists

When an anesthesiologist is not personally administering the anesthesia but is providing medical direction for the services of a nurse anesthetist who is not employed by the anesthesiologist, the anesthesiologist may bill for the medical direction. Medical direction includes the pre and postoperative evaluation of the patient. The anesthesiologist must remain within the operating suite, including the pre-anesthesia and post-anesthesia recovery areas, except in extreme emergency situations. Reimbursement for medical direction by anesthesiologists must be at the provider's usual charge or 50 percent of the ARA, whichever is less.

(10) Anesthesia by Surgeon

(a) Local Anesthesia

When infiltration, digital block or topical anesthesia is administered by the operating surgeon or surgeon’s assistant, reimbursement for the procedure and anesthesia are included in the global reimbursement for the procedure.

(b) Regional or General Anesthesia

When regional or general anesthesia is provided by the operating surgeon or surgeon's assistant, the surgeon may be reimbursed for the anesthesia service in addition to the surgical procedure.

1. To identify the anesthesia service, list the CPT surgical procedure code and add Modifier 47.

2. Reimbursement shall be the lesser of the provider's usual charge or the ARA.

The operating surgeon must not use the diagnostic or therapeutic nerve block codes to bill for administering regional anesthesia for a surgical procedure.

(11) Unlisted Service, Procedure or Unit Value: When an unlisted service or procedure is provided or without specified unit values, the values used shall be substantiated "BR" (By Report).

(12) Procedures Listed In The ASA Relative Value Guide Without Specified Unit Values: For any procedure or service that is unlisted or without specified unit value, the physician or anesthetist shall establish a unit value consistent in relativity with other unit values shown in the current ASA Relative Value Guide. Pertinent information concerning the nature, extent and need for the procedure or service, the time, the skill and equipment necessary, etc., is to be furnished. Sufficient information should be furnished to identify the problem and the service(s).

(13) Actual time of beginning and duration of anesthesia time may require documentation, such as a copy of the anesthesia record in the hospital file.

(14) Special Supplies: Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered may be listed separately. Drugs, materials provided, and tray supplies shall be listed separately. Supplies and materials provided in a hospital or other facility must not be billed separately by the physician or CRNA. These charges must be billed by the hospital.

(15) Separate or Multiple Procedures: It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.

0800-2- -.06 Injections Guidelines

General Information and Guidelines

Reimbursement for injection(s) (such as J codes) includes allowance for CPT code 90782 in addition to average wholesale price of each drug. In cases where multiple drugs are given as one injection, only one administration fee is owed.

Surgery procedure codes defined as injections include the administration portion of payment for the medications billed.

J Codes are found in the Health Care Financing Administration Common Procedure Coding System (HCPCS).

0800-2- -.07 Ambulatory Surgical Treatment ("ASTs") and Outpatient Hospital Care

Medicare ASC rates shall be used as the basis for fees charged for services provided in an ambulatory surgical treatment center (ASTC) and shall be reimbursed at a maximum of 100% of current value for such care at ASTCs under Medicare. Outpatient hospital care shall be reimbursed at a maximum rate of 100% of the current value of Medicare reimbursement for outpatient hospital care.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2- -.08 Chiropractic Services Guidelines

(1) Charges for chiropractic services shall not exceed one hundred thirty percent (130%) of the participating fees prescribed in the Medicare Resource Based Relative Value Scale System fee schedule (Medicare Fee Schedule).

(2) For chiropractic services, an office visit shall not be billed on the same day as a manipulation is billed.

(3) If allowable payment for chiropractic services is not paid by employers or insurers for chiropractic services provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty (30) days from the date of receipt by the employer or insurer of the bill for chiropractic services provided to such an employee, interest at the rate of 1.5%/month of the payment allowed pursuant to these rules may be charged by a chiropractor for every thirty (30) day period during which payment has not been made.

(4) There shall be no fee allowable for any modalities performed in excess of four (4) modalities per day per employee.

(5) There shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.

0800-2- -.09 Physical and Occupational Therapy Guidelines

(1) Charges for physical therapy and/or occupational therapy services shall not exceed one hundred thirty percent (130%) of the participating fees prescribed in the Medicare Resource Based Relative Value Scale System fee schedule (Medicare Fee Schedule).

(2) For physical therapy and/or occupational therapy, there shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.

(3) For physical therapy and/or occupational therapy, there shall be no fee allowable for any modalities performed in excess of four (4) modalities per day per employee.

(4) Whenever physical therapy and/or occupational therapy services exceed fifteen (15) sessions/visits or a period over thirty (30) days, whichever comes first, then such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in 0800-2-6 of the Division's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the carrier. Failure to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of sessions/visits. If necessary, further subsequent utilization review shall be conducted to certify additional physical therapy and/or occupational therapy services as is appropriate.

0800-2- -.10 Durable Medical Equipment (DME) Guidelines

Supplies and equipment addressed in this fee guideline will be reimbursed at a reasonable amount. Supplies and equipment not addressed in this fee guideline will be reimbursed at a reasonable amount and coded 99070. All billing must contain the brand name, model number, and/or catalog number. Codes to be used are found in the HCPCS.

(1) Quality

The reimbursement for supplies/equipment in this fee guideline is based on a presumption that the injured worker is being provided the highest quality of supplies/equipment. All billing must contain the brand name, model number, and/or catalog number, and a copy of the invoice.

(2) Rental/Purchase

Rental fees are applicable in instances of short-term utilization (30-60 days). If it is more cost effective to purchase an item rather than rent it, this must be stressed and brought to the attention of the insurance carrier. The first month's rent should apply to the purchase price. However, if the decision to purchase an item is delayed by the insurance carrier, subsequent rental fees cannot be applied to the purchase price. When billing for rental, identify with modifier "RT".

(3) TENs Units

All bills submitted to the carrier for Tens and Cranial Electrical Stimulator (CES) units must be accompanied by a copy of the invoice.

(a) Rentals

1. Include the following supplies:

(i) lead wires;

(ii) three (3) rechargeable batteries;

(iiiI) battery charger;

(iv) electrodes; and

(v) instruction manual and/or audio tape.

2. Supplies submitted for reimbursement must be itemized. In unusual circumstances where additional supplies are necessary, use modifier 22 and "BR"

3. Limited to 30 days trial period.

(b) Purchase:

1. Prior to the completion of the 30-day trial period, the prescribing doctor must submit a report documenting the medical justification for the continued use of the unit. The report should identify the following:

(i) Describe the condition and diagnosis that necessitates the use of a TENs unit.

(ii) Does the patient have any other implants which would affect the performance of the TENs unit or the implanted unit?

(iii) Describe how the TENs unit will be utilized in the treatment plan.

(iv) Who/how was the unit evaluated for effective pain control during the trial period?

(v) Who/how was the patient instructed in the use of the unit?

(vi) And how often does the patient use the unit and under which conditions is it used?

2. The purchase price should include:

(i) lead wires;

(ii) three (3) rechargeable batteries; and

(iii) a battery charger.

3. Only the first month's rental price will be credited to purchase price.

4. Provider will indicate TENs manufacturer, model name, and serial number as shown on invoice.

5. All TENs units and supplies are listed in the DME list.

(4) Continuous and Passive Motion (Use Code D0540)

Use of this unit in excess of 30 days requires documentation of medical necessity by the doctor. Only one (1) set of soft goods will be allowed for purchase.

0800-2- -.0-11 Orthotics, Prosthetics and Implants Guidelines

Reimbursement for orthotics, implants and prosthetics shall be based on reasonableness and necessity. Orthotics and prosthetics should be coded according to the HCFA Common Procedures Coding System and billed By Report (BR). Copies may be obtained from the American Orthotic and Prosthetic Association, 1650 King Street, Suite 500, Alexandria, VA 22314, (703) 836-7116.

0800-2- -.12 Pharmacy Schedule Guidelines

The Pharmaceutical Fee Guideline for prescribed drugs (medicines by pharmacists and dispensing practitioners) under the Tennessee workers' compensation laws is the lesser of:

(1) The provider's usual charge; or

(2) The fees established by the formula for brand-name and generic pharmaceuticals as described in subsection (2) of this section.

(3) Prescribed Medication Services

(a) "Medicine" or "drugs" shall be defined by Tenn. Code Ann. § 53-1-102.

(b) Medicine or drugs may only be dispensed by a currently licensed pharmacist or a dispensing practitioner.

(c) For the purposes of the TWCD Medical Fee Schedule, medicines are defined as drugs prescribed by an authorized health care provider and include only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes that the brand name is medically necessary and includes on the prescription "dispense as written" or "DAW."

(4) Reimbursement

(a) The pharmaceutical reimbursement formula for prescribed drugs (medicines by pharmacists and dispensing practitioners) is the lesser of:

For generics, Average Wholesale Price ("AWP") + 10% + $5.50 filling fee, or the provider's usual charge

For brand name: AWP + $5.50 filling fee; or the provider's usual charge.

(b) Reimbursement to pharmacists must not exceed the amount calculated by the pharmaceutical reimbursement formula for prescribed drugs. Approved generics shall be substituted for brand name pharmaceuticals unless the prescribing physician certifies no substitution is permitted.

1. A bill or receipt for a prescription drug shall include all of the following:

(i) When a brand name drug with a generic equivalent is dispensed, the brand name and the generic name shall be included unless the prescriber indicates “do not label.”

(ii) If the drug has no brand name, the generic name, and the manufacturer’s name or the supplier's name, shall be included, unless the prescriber indicates “do not label.”

(iii) The strength, unless the prescriber indicates “do not label.”

(iv) The quantity dispensed.

(v) The dosage.

(vi) The name, address, and federal tax ID# of the pharmacy.

(vii) The serial number of the prescription, if available.

(viii) The date dispensed.

(ix) The name of the prescriber.

(x) The name of the patient.

(xi) The price for which the drug was sold to the purchaser.

(xii) The NDC Number (National Drug Code Number).

2. The AWP shall be determined from the appropriate monthly publication. The monthly publication that shall be used for calculation shall be the same as the date of service. When an AWP is changed during the month, the provider shall still use the AWP from the monthly publication. The publications to be used are:

a. Primary reference. PriceAlert from First Data Bank.

b. Secondary reference (for drugs NOT found in PriceAlert). Red Book from Medical Economics.

3. Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured employee as a result of the work-related injury.

4. A compounding fee not to exceed Twenty-five Dollars ($25.00) per compound prescription may be charged if two (2) or more prescriptive drugs require compound preparation when sold by a hospital, pharmacy, or provider of service other than a physician.

5. If allowable payment for prescriptive drugs is not paid by employers or insurers for prescriptions provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty (30) days from the date of receipt by the employer or insurer of the bill for prescriptive drugs provided to such an employee, interest at the rate of 1.5% /month of the payment allowed pursuant to these rules may be charged by a hospital, pharmacy, or provider of service other than a physician for every thirty (30) day period during which payment has not been made.

6. If a workers' compensation claimant chooses a brand-name medicine when a generic medicine is available and allowed by the prescriber, the claimant shall pay the difference in price between the brand-name and generic medicine and shall not be eligible to subsequently recover this difference in cost from the employer or carrier.

(5) "Patent" or 'Proprietary Preparations"

(a) "Patent" or "Proprietary preparations," frequently called "over-the-counter drugs," are sometimes prescribed for a work-related injury or illness instead of a legend drug.

(b) Generic substitution as discussed in (4)(b) above applies also to "over-the-counter" preparations.

(c) Pharmacists must bill and be reimbursed their usual and customary charge for the "over-the-counter" drug(s).

(d) The reimbursement formula does not apply to the "over-the-counter" drugs and no filling fee may be reimbursed.

(6) Dispensing Practitioner

(a) Dispensing practitioners shall be reimbursed the same as pharmacists for prescribed drugs (medicines), except they shall not receive a filling fee.

(b) "Patent" or "proprietary preparations" frequently called "over-the-counter drugs," dispensed by a physician(s) from their office(s) to a patient during an office visit should be billed as follows:

1. Procedure Code 99070 must be used to bill for the "proprietary preparation" and the name of the preparation, dosage and package size must be listed as the descriptor.

2. An invoice indicating the cost of the "proprietary preparation" must be submitted to the carrier with the HCFA 1500 Form.

3. Reimbursement is limited to the provider's charge or up to 20 percent above the actual cost of the item.

0800-2--.13 Ambulance Services

(1) All non-emergency ground and air ambulance service provided to workers' compensation claimants shall be pre-certified. Emergency ground and air ambulance services shall be retro-certified within 24 hours of the service or on the next working day.

(2) All ground and air ambulance services shall be medically necessary and appropriate. Documentation, trip sheets, shall be submitted with the bill that states the condition that indicates the necessity of the ground and air ambulance service provided. It should readily indicate the need for transport via this mode rather than another less expensive form of transportation. The service billed shall be supported by the documentation submitted for review.

(3) Billing shall be submitted to the employer or carrier on a properly completed HCFA 1500 claim form by HCPCS code. Hospital based or owned providers must submit charges on a HCFA 1500 form by HCPCS code.

(4) Reimbursement shall be:

Based upon the lesser of the submitted charge or the prevailing reimbursement rate for ambulances within the geographic locality. These charges shall not exceed the prevailing charges in that locality for comparable services under comparable circumstances and commensurate with the services actually performed. Ambulance services shall be paid on a two (2) part basis, the first level being the level of care, the second being a mileage allowance. The services rendered are independent of the type of call received or the type of staff and/or equipped ambulance responding.

0800-2- -.14 Clinical Psychological Service Guidelines

(1) Reimbursement for psychological treatment services by any clinician other than a licensed psychiatrist shall be based on reasonableness and necessity and shall be reimbursed at 100% of the participating fees prescribed in the Medicare Resource Based Relative Value Scale System fee schedule (Medicare Fee Schedule). Treatment by a licensed psychiatrist shall be reimbursed as any other medical treatment.

(2) Whenever such psychological treatment services exceed fifteen (15) sessions/visits or a period over thirty (30) days, whichever comes first, then such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in 0800-2-6 of the Division's Utilization Review rules before further psychological treatment services may be certified for payment by the carrier. Failure to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. The initial utilization review of psychological treatment services shall, if necessary and appropriate, certify an appropriate number of sessions/visits. If necessary, further subsequent utilization review shall be conducted to certify additional psychological treatment services as is appropriate.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).